

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Penfield Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Penfield Rd Penfield, NY 14526	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>46880</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey from 01/27/2025 to 01/31/2025, for one (Resident #13) of five residents reviewed, the facility did not ensure a resident was clinically appropriate to self-administer medications. Specifically, Resident #13 was observed to have multiple medications left on their bedside table and there was no documented evidence their ability to self-administer medications had been assessed or care planned for. This is evidenced by the following:</p> <p>Review of the facility policy Comprehensive Care Plan, dated November 2016, revealed the Comprehensive Care Plan for each resident would include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that were identified on the comprehensive assessment. The care plan would be reviewed and updated as necessary on a quarterly basis and the ability to self-medicate would be reviewed at each care conference.</p> <p>Resident #13 had diagnoses that included dementia with mood disturbance, depression, and diabetes mellitus. The Minimum Data Set Resident Assessment, dated 10/26/2024, included the resident was cognitively intact and took high risk medications including an antidepressant, diuretic (medications that help the kidneys remove extra water and salt through the urine), and hypoglycemic (a medication that reduces the amount of sugar present in the blood).</p> <p>Review of the current Comprehensive Care Plan, initiated on 12/29/2024, did not include measurable goals or interventions for Resident #13 to self-administer medications.</p> <p>Review of current medical orders, did not include an order for Resident #13 to self-administer medications. Additional review of Resident #13's electronic health record did not include documentation of an interdisciplinary team decision that the resident was clinically appropriate to self-administer medications.</p> <p>During an observation and interview on 01/30/2025 at 10:13 AM, Resident #13 was sitting in their room and an unlabeled undated medicine cup that contained approximately 18 pills, including but not limited to, several Tylenol tablets and a Metformin (an anti-diabetic medication) tablet, was on their bedside table. There was no nurse in the area or in site at that time. Resident #13 stated they did not know all of the medications they were taking and pills were often left for them to take unsupervised depending on the nurse (who administered the medications). Resident #13 stated they were slow to take their pills because they preferred to wait until they had something to eat.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/30/2025 at 10:30 AM, Licensed Practical Nurse #1 stated Resident #13 had not eaten yet and took a long time to take their pills. Licensed Practical Nurse #1 stated they had left pills with the resident before, but knew residents needed to be evaluated and approved by a medical provider before taking their medications unsupervised.</p> <p>During an interview on 01/30/2025 at 12:42 PM, the Director of Nursing stated for residents to have medications left at their bedside unsupervised, they should be alert and oriented, know their medications, and have a care plan in place (to self-administer).</p> <p>During an interview on 01/31/2025 at 10:22 AM, Physician Assistant #1 stated they did not know Resident #13 very well, but the resident previously had a medical order to leave medications at their bedside. Physician Assistant #1 stated following an assessment of Resident #13 earlier in the day, they thought the resident had experienced some changes in their cognition and awareness.</p> <p>During an interview on 01/31/2025 at 12:59 PM, the Director of Nursing stated they were unable to find documentation Resident #13 had been assessed for their ability to self-administer medications. The Director of Nursing stated an assessment should have been completed and a care plan initiated before medications were left at the bedside.</p> <p>10 NYCRR 415.3(f)(1)(vi)</p>		

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<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46880</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey from 01/27/2025 to 01/31/2025, for one (Resident #13) of one resident reviewed for oxygen use, the facility did not develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs including resident goals, desired outcomes and preferences. Specifically, there was no comprehensive care plan including goals and interventions for the resident's respiratory disease and oxygen therapy requirements. This is evidenced by the following:</p> <p>Review of the Comprehensive Care Plan Policy, revised November 2016, documented in part, it is the policy of this facility that each resident has an interdisciplinary, comprehensive care plan. The care plan summarizes the team approach to active and /or potential problems or concerns based on the Care Area Assessments as per regulatory requirements. The Comprehensive Care Plan for each resident includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified on the comprehensive assessment. The Certified Nurse Assistant Resident Care Plan is also a part of the Comprehensive Care Plan which includes specific schedules/actions necessary to provide resident care.</p> <p>Resident #13 had diagnoses that included acute respiratory failure with hypoxia (decreased oxygen in the body), pulmonary emboli (blood clot to the lungs), wheezing and anxiety. The Minimum Data Set Resident Assessment, dated 10/26/2024, revealed Resident #13 was cognitively intact and received oxygen therapy.</p> <p>Review of current physician's orders, initiated 05/14/2024, documented oxygen per nasal cannula at two liters for comfort around the clock (nights, days, evenings shifts).</p> <p>Review of Resident #13's current (undated) Comprehensive Care Plan, and the Certified Nurse Assistant Resident Care Plan, did not include any information related to the resident having a respiratory related medical condition or that they were receiving oxygen therapy around the clock.</p> <p>During an observation on 01/27/2025 at 10:24 AM, Resident #13 was sitting in their wheelchair in their room. The resident was receiving oxygen via nasal cannula from an oxygen concentrator at two liters. The humidifier bottle (water bottle that delivers humidified air to the oxygen) attached to the oxygen concentrator was completely empty of water and unclean.</p> <p>During an observation on 01/29/2025 at 1:25 PM, Resident #13 was asleep in bed with their nasal cannula in place receiving oxygen at two liters.</p> <p>During an interview on 01/29/2025 at 3:05 PM, the Director of Nursing stated the facility was in the process of switching electronic health records software and even if the resident's information had not yet switched over, both electronic health records should have the same up to date information.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/30/2025 at 10:30 AM, Licensed Practical Nurse #1 stated Resident #13 always wore oxygen and they should be care planned for it, and their nursing interventions should include their oxygen settings, how often to change the tubing, and if they required humidification.</p> <p>During an interview on 01/30/2025 at 12:42 PM and again at 3:43 PM, the Director of Nursing stated the nurse managers were responsible for initiating the care plans, and afterwards other members of the interdisciplinary team should add to the care plan. Resident #13 should have been care planned for oxygen with interventions to fill the humidifier bottle every shift and change the humidifier bottle and oxygen tubing once weekly. The Director of Nursing stated prior to today, Resident #13 did not appear to be care planned for oxygen, but should have been and it was an oversight.</p> <p>10 NYCRR 415.11(c)(1)</p>		